

Becket Systems

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DATE NOTICE SENT TO ALL PARTIES: Mar/17/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Sacroiliac Joint Injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Anesthesiologist and Board Certified Pain Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for sacroiliac joint injection is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is XX/XX/XX. On this date the patient slipped on a wet floor and fell. The patient underwent lumbar epidural steroid injection at L5-S1 on XX/XX/XX. The patient subsequently underwent lumbar laminectomy/discectomy left L5-S1 on XX/XX/XX. Peer review dated XX/XX/XX indicates that the patient was working at a full time capacity at that time. Office visit note dated XX/XX/XX indicates that the surgery relieved a good deal of the radicular pain. She has continued pain in her back, buttock and left side. Office visit note dated XX/XX/XX indicates that indicates physical examination straight leg raising is positive on the left. Deep tendon reflexes are normal in the lower extremities. Hip maneuvers are negative. Office visit note dated XX/XX/XX indicates that current medications include biotin, calcium, cranberry, cyanocobalamin, docusate sodium, Fergon, fiber, glucosamine, hydrocodone-acetaminophen, Naprosyn and omeprazole. On physical examination lower extremity range of motion is good without pain. Lumbar range of motion is mildly diminished. There is decreased sensation on the lateral aspect of the calf and foot in the S1 dermatome. Reflexes are symmetric. Motor strength is intact. Diagnoses are lumbar radiculopathy, postlaminectomy syndrome, other intervertebral disc degeneration of the lumbar region. Note dated XX/XX/XX indicates that hip maneuvers are negative. There is tenderness over the left PSIS.

The initial request for sacroiliac joint injection was non-certified on XX/XX/XX noting that sacroiliac joint injections are not recommended. Recent failure of lower levels of care was not noted such as physical therapy. Objective documentation supporting sacroiliac disease was not noted as required by the guidelines. The denial was upheld on appeal dated XX/XX/XX noting that there is no credible evidence that the left SIJ is a pain generator. The request is not supported by ODG.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries as a result of a fall on XX/XX/XX. The patient subsequently underwent lumbar laminectomy/discectomy

left L5-S1 on XX/XX/XX. There is no documentation of any recent active treatment. The patient's physical examination fails to document findings indicative of sacroiliac joint dysfunction. The Official Disability Guidelines no longer support the performance of this procedure. As such, it is the opinion of the reviewer that the request for sacroiliac joint injection is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)